SETTING THE RECORD STRAIGHT ON THE AFFORDABLE CARE ACT:

MYTH #1: ObamaCare adds trillions to our deficits and to our national debt.
FACT: ObamaCare was fully paid for and, in fact, its savings are projected to substantially reduce the deficit over the near- and long-term.
• An updated estimate for repeal is not available. Under the July 2012 CBO estimate, health care reform will reduce the deficit by $109 billion over the next 10 years.
• The original estimate upon enactment showed even greater deficit reduction in the second decade and beyond.

MYTH#2: The ACA cuts Medicare.
FACT: The ACA actually preserved and improved Medicare benefits, reduced cost-sharing and extended solvency.
• The ACA strengthens Medicare's financing and solvency outlook while improving seniors' benefits. In fact, 6.6 million senior citizens and people with disabilities have received $7 billion in Medicare prescription drug savings because of the ACA.
• Following enactment of the ACA, Medicare's per capita growth is at an all-time low.
• The ACA's savings extended Medicare's solvency by eight years.
• The ACA ended unjustified and unaccountable overpayments to private plans and other providers that increased premiums and drained the Medicare trust fund.
• These payment changes helped fund Medicare modernizations and improvements, including free preventive benefits, closing the prescription drug donut hole, and implementing delivery system reforms to improve quality and reduce costs.

MYTH #3: ObamaCare is not ready to start, and rollout will be rocky.
FACT: Administration officials have continued to reiterate that the federally-facilitated Marketplaces (a.k.a. Exchanges) will be ready to go on time in the 34 states that will be relying – in whole or in part -- on the federal marketplaces; States running their own Marketplaces have also said they will be ready to go.
• The Administration has repeatedly stated that they will be ready for the October 1, 2013 open enrollment.
• The Administration is working with states and health insurers to make certain that the IT systems and enrollment process is working on the federal, state and private sector levels.
• Over 90 percent of regulations have been completed in preparation for implementing the Marketplaces.
• Recent GAO reports show that the Obama Administration has made much progress in the establishment of health insurance marketplaces and that CMS has adjusted and planned to make sure the Marketplaces are implemented on time.

MYTH #4: The ACA is a massive tax increase on the American people.
FACT: The tax credits in the ACA amount to a tremendous tax *cut* for millions of families.
• The ACA is a tax CUT, and NOT a tax increase for middle-class families. This scare tactic was debunked by the Washington Post Factchecker (7/6/12).
• Individuals who can afford to purchase insurance, but choose not to do so, pay a penalty to help offset their inevitable costs to the system. Only 2.1 percent of non-elderly Americans are projected to be affected by the individual responsibility penalty.
• The ACA delivers $1.7 trillion in new benefits over 10 years, including more than $700 billion to help states pay for Medicaid coverage expansions for lower income families, $14 billion in tax credits for small businesses that provide employee health coverage, and more than $1 trillion in tax credits and other assistance to help individuals and families purchase affordable coverage.
• The ACA is crafted so that the health care sectors most likely to benefit from 27 million newly insured individuals – medical device manufactures, the pharmaceutical industry, health insurance companies,

providers – contribute to the cost of providing this coverage. Even with these contributions, these sectors are expected to see significant growth in business in the coming years due to 27 million new customers.
• While the ACA does increase taxes for households earning more than $250,000 ($200,000 for individuals) per year (through an additional 0.9% tax on earned income and a 3.8% tax on unearned income), only three percent of American families are affected by this provision.

MYTH #5: Applying for health insurance in the Marketplaces will be a complicated, long, and burdensome process.
FACT: Applying for health insurance in the Marketplaces will be straightforward and far less complicated than the current individual market application process.
• The application for health insurance purchased through the Marketplaces is much shorter and less invasive than: (1) the current applications for insurance coverage in the individual market, (2) student loan applications, and (3) Fannie Mae or other mortgage/housing programs.
• While the application requires modest preparation (e.g., must have certain documents available, etc.), the Administration estimates that it will take approximately seven minutes for an individual to fill out the application.
• The online version of the application is designed to direct the user based on responses to previous questions. For example, if an applicant is applying as an individual, the online application will skip all questions related to other family members or dependents. This will tailor, and in many cases shorten, the application process for those applying online.

MYTH #6: Health costs are increasing as a result of the ACA.
FACT: Health inflation has slowed dramatically since the enactment of the ACA.
• In 2012, overall growth in health spending was at a historic low for the third year in a row. Total U.S. health spending grew 3.9 percent in 2011 – the same rate of growth as in 2009 and 2010.
• CBO estimates that the ACA will decrease premiums in the individual market for same-service health insurance by seven to ten percent, and will reduce premiums in the small group market for same service health insurance by up to two percent.

MYTH #7: The ACA will increase health insurance premiums.
FACT: While the ACA may be a convenient scapegoat for insurance company abuses, independent analyses find that premiums are lower than they would be absent the ACA, even before the Exchanges and tax credits are available.
• Even prior to the start of Exchanges or Marketplaces, medical loss ratio (MLR), rebate and rate review provisions from the ACA have helped provide better value for premium dollars.
• For 2012, the ACA saved consumers almost $4 billion. Approximately 78 million consumers saved $3.4 billion on their premiums as a result of insurance plans lowering rates to meet the MLR provision. Additionally, 8.5 million consumers will receive $500 million in rebates, an average rebate of around $100 per family.
• For 2011, 13 million consumers received $1.1 billion in rebates from private health insurers as a result of the ACA's requirements that insurance companies provide more health care value for premiums paid.
• Insurance companies can no longer arbitrarily raise health insurance premiums. Thanks to the ACA, proposed rate increases greater than 10 percent are reviewed, approved, or denied at the state or federal level.

MYTH #9: ObamaCare hurts small businesses
FACT: Small businesses are exempt from the ACA's requirements, though the law has a number of a provisions that help small businesses who choose to offer coverage, including tax credits to support coverage and new Marketplaces that give them greater purchasing power and options.

• Businesses with fewer than 50 employees are not required to contribute to or offer insurance to their employees. However, for those that choose to do so, the ACA offers a targeted tax credit to help some small businesses pay for their workers' coverage.
• Thanks to the ACA, 360,000 small businesses are already receiving tax credits to help with the cost of providing coverage to their workers.
• Small businesses will also benefit from the Marketplace reforms that come into effect in 2014. These exchanges will reduce premiums for small businesses through lower administrative costs, increased competition among insurers, increased transparency of costs, and better risk pools.
• Small businesses also benefit from the non-discrimination provisions. Prior to the ACA, premiums for the entire small business could rise exponentially simply because one worker got cancer or gave birth to a premature child.

MYTH #10: By delaying employer responsibility provisions for one year, the Obama Administration gave relief to big businesses, but not to individuals.
FACT: The Administration's action was designed to make it easier for businesses *and* workers to comply with the new requirements.
• The law already provides for a phase-in period for the individual responsibility requirement with the first year penalty being $95 per person (less than $8 per month), capped at $285 per family, with hardship exemptions for those in need. The decision to delay the employer reporting requirements (while asking organizations to voluntarily begin reporting) allows a similar phase-in of the employer responsibility provisions.
• Additionally, middle-class individuals and families without access to affordable employer coverage can qualify for premium tax credits and other subsidies to afford coverage in the exchanges.
• The vast majority of large businesses (95 percent of employers with 50+ employees) already offer coverage to their workers, even without the requirement to offer coverage or contribute to the cost of care. Delaying these provisions shouldn't change that.

MYTH #10: Employers will drop insurance for their employees.
FACT: Most independent, non-partisan experts agree that the ACA will not lead to a drop in employer-sponsored insurance.
• Employer-sponsored insurance (ESI) is the backbone of our country's health insurance system, and the ACA builds upon this model. The overwhelming majority of Americans will continue to obtain health coverage through an employer.
• 95 percent of employers with 50+ employees already *voluntarily* provide coverage to their workers because it is necessary to recruit and retain a quality workforce, evidence that they will continue to do so.
• CBO and other nonpartisan experts estimate that there will be only a modest reduction in ESI, including a number of people who can now purchase affordable coverage elsewhere and *choose* to leave their job-based coverage for entrepreneurial opportunities or to care for a child.
• Since Massachusetts enacted its health reform law, the number of people covered by ESI *increased* by about 1 percentage point while for the rest of the nation ESI *declined*.

MYTH #11: You can only buy government-approved or regulated insurance.
FACT: Virtually all health insurance products have always been regulated by either federal or state governments.
• States have historically had the primary responsibility to regulate certain health insurance products. While the rigor of state law and enforcement may vary, all states require approval of a product before it can be sold in the state. The federal ERISA law has long controlled for most employer-sponsored insurance, and federal law governs many of the federal programs (e.g., Medicare, Medicaid, VA/DOD coverage, etc.).
• The ACA built on this federal-state model by creating a "floor" of regulatory provisions to ensure uniform consumer protections irrespective of where people live. It deferred substantially to states for enforcement and other regulatory action.

• Ironically, some of the most conservative states that one might assume would be most interested in protecting "states' rights" are those that instead have invited the federal government to manage their products.

MYTH #12: ObamacCare creates a new agency to put the federal government between you and your doctor.

FACT: Nothing could be further from the truth.

• The ACA strengthens the doctor-patient relationship by providing physicians with new information and tools, such as research on the relative effectiveness of various treatments, that will help patients and physicians make informed health decisions.

• Contrary to claims, the ACA specifically prohibits the Patient-Centered Outcomes Research Institute (PCORI) from dictating practice guidelines or coverage, payment, or policy recommendations.

• The ACA puts patient well-being above insurance company bottom lines by implementing necessary – and long overdue – consumer protections that limit the insurance industry's control over health care access and keep health care decisions where they ought to be – between doctors or nurses and their patients.

MYTH #13: The IRS will be 'in charge of your health care'

FACT: This is another scare tactic to raise unnecessary fears about the IRS handling people's health care.

• The IRS will NOT be in charge of anyone's health care. This is nothing more than another scare tactic, and was debunked by the Washington Post Factchecker (5/29/13).

• The IRS will only collect data it routinely receives in the context of tax administration (e.g., name, address, family size, income, etc) and information about whether an individual or family was covered by insurance.

MYTH #14: The IRS will pursue and jail Americans who do not purchase insurance.

FACT: This is nothing but fear mongering, plain and simple.

• The ACA explicitly prohibits the IRS from seizing property or putting anyone in jail for failure to meet the individual responsibility requirement.

MYTH #15: The ACA is a "job-killer."

FACT: The economy has grown post-passage of the ACA and unemployment is declining.

• Since the passage of the ACA in March 2010, private employers have added 6.7 million jobs and the health sector has added 808,400 jobs.

• CBO and the Business Roundtable found that employers will benefit from lower health care costs, freeing funds to hire more workers. According to CBO, employer premiums will fall by as much as three percent in the large group market and two percent in the small group market.

• This claim was independently debunked by factcheck.org. What CBO actually said was "*the legislation, on net, will reduce the amount of labor used in the economy by a small amount – roughly half a percent – primarily by reducing the amount of labor that workers choose to supply*." Essentially, the ACA ends job-lock by giving people the option to pursue entrepreneurial ideas, stay home with their children or retire early rather than being tied to their jobs for health insurance.

MYTH #16: Millions of Americans will lose health insurance coverage.

FACT: This is false. In fact, according to CBO, nearly 27 million *more* people will be insured once the ACA is fully in effect.

• This claim is the result of an unrealistic, partisan alternative scenario that CBO was directed to analyze and which CBO then criticized as highly unlikely to occur.

• CBO and other nonpartisan experts estimate that there may be a modest reduction in some types of coverage, but it will be more than offset by gains from other sources.

MYTH #17: The ACA will dramatically increase health insurance premiums for young people or others purchasing insurance from Marketplaces.

FACT: A significant majority of those in the new Marketplaces are likely to pay less or the same amount for their insurance, even without tax credits. With tax credits, the premiums will be even lower.

• Many states (e.g., New York, Washington, California, and Montana) have seen preliminary premium filings with stable or even lower premiums for individuals purchasing insurance from Marketplaces. The initial premium filings submitted were below projections and, in some cases, below current individual premiums. There is no evidence of so-called "rate shock."

• In Oregon and DC, insurance plans have re-submitted preliminary premiums with significant reductions showing that competition and transparency in the Marketplaces are working to keep premiums affordable.

• Many people in the Marketplaces will pay less than they do today, thanks to premium tax credits. CBO estimates that in 2014, 86 percent of people who get their coverage through the Marketplaces will receive these tax credits, and the average credit will be more than $5,000 a year, or more than $400 a month.

• People in the new Marketplaces will also get better health insurance benefits than they currently receive. Beginning in 2014, people who buy their health insurance in the Marketplaces will have access to prescription drug coverage, maternity coverage, and mental health coverage – benefits that are often excluded from individual market plans today.

• Individuals in the Marketplaces will also be protected from being dropped or charged more if they use their policy or have a pre-existing condition.

• Many women will have lower premiums because of non-discrimination provisions that prevent insurers from charging women more just because of their gender.

• Similarly, older men will see their premiums drop because of new rules that minimize age discrimination in the Marketplaces.

MYTH #18: This is government taking over the entire health insurance industry.

FACT: In fact, the ACA is built largely on current private sector coverage (along with Medicaid coverage for those with very low incomes).

• This oft-repeated phrase is nothing but a scare tactic. The real scary thing is that some want to take away individual freedom and control over health care choices, and return power to insurance companies that deny or charge more for insurance because an individual is unfortunate enough to be a cancer patient, elderly, or simply born a female.

• Under the ACA, coverage will continue to be provided by private insurers and most people will continue to get their coverage through employers. People will continue to get items and services from private doctors, private hospitals, private medical device companies, private pharmaceutical manufacturers and other private sector companies. That's hardly a government takeover.

MYTH #19: The IRS will have access to personal health information.

FACT: The IRS will not have access to personal health information at all. The only information that the IRS will have is the same type of information that is currently used to process tax returns – e.g., name, taxpayer ID number, address, family size, etc. – and whether the individual or family is covered by insurance.

• Contrary to today's market, in which people applying for health insurance have to provide countless personal details of previous or current health conditions and treatments, none of that information is necessary to enroll in a plan.

• In fact, because the ACA prohibits discrimination on the basis of pre-existing conditions, personal health data is not required. Neither IRS nor HHS will have access to medical records or other personal health history;

MYTH #21: The IRS will have to hire 17,000 new IRS agents to enforce the ACA.
FACT: This claim has repeatedly been debunked.
• During last year's identical repeal effort, the AP ran a story with the following quote from an IRS spokesperson: *"That is a made-up number with no basis in fact. The 2012 budget calls for about 1,200 employees for the IRS to implement the (Affordable Care Act), and the vast majority of those employees are needed to build technology infrastructure to support payments like the new tax credits for individuals and small businesses."*
• The 2014 budget request by the IRS for ACA implementation is similar: 2,000 employees with 85 percent of those employees being used to build technology for the delivery of tax credits and to provide customer support for taxpayers inquiring about the law.

MYTH #22: Illegal immigrants will receive ACA-sponsored health care.
FACT: The law is clear that assistance is only available to persons who are "lawfully present" in the United States.
• Every application will be screened against the Homeland Security database to ensure that only eligible citizens or others who are lawfully present obtain tax credits or other assistance under the ACA.

MYTH #25: A board of unelected bureaucrats (the Independent Physician Advisory Board, or IPAB) will ration care.
FACT: This is patently false.
• The ACA explicitly prohibits IPAB from making any changes that ration care or increase Medicare premiums or cost sharing.

MYTH #26: The ACA allows federal funding to be used for abortions.
FACT: This is not true.
• Current law states that **no** Federal funds will be used for abortion, except in the case of rape, incest, or when the life of the woman is in danger. Individuals may purchase additional abortion coverage with their own funds if such coverage is made available. No federal dollars may be used for this purpose.
• No private insurance company is required to provide abortion coverage. If they chose to do so, private dollars paid by subscribers for the coverage must be segregated in a separate account. No private dollars for abortion coverage may be co-mingled with any public dollars.